114.2 CMR 4.00: RATES OF PAYMENT TO RESIDENT CARE FACILITIES
Section

4.01: General Provisions

(1) Scope and Effective Date. 114.2 CMR 4.00 governs prospective rates of payment without final settlement on and after October 1, 2005 for services rendered to Publicly-Aided Residents in Resident Care Facilities. The rates set forth in 114.2 CMR 4.00 also apply to individuals covered by M.G.L.c. 152 (the Worker's Compensation Act) as specified in 114.3 CMR 40.02(4)(a)1. Residential Care Units of Nursing Facilities are governed by 114.2 CMR 6.00, Standard Payments to Nursing Facilities.

(2) Authority. 114.2 CMR 4.00 is adopted pursuant to M.G.L. c. 118G.

4.02: General Definitions

Meaning of Terms. As used in 114.2 CMR 4.00, unless the context requires otherwise, terms have the meanings ascribed in 114.2 CMR 4.02. For easy reference, all defined terms in 114.2 CMR 4.00 are capitalized.

Actual Utilization Rate. The percentage of occupancy of a Resident Care Facility. It is calculated by dividing total Resident Days by Maximum Available Bed Days.

Additions. New units or enlargements of existing units that may or may not be accompanied by an increase in Licensed Bed Capacity.

Average Equity Capital. The average of the difference between a Provider's beginning and ending allowable book value, calculated pursuant to 114.2 CMR 4.09, and the Provider’s beginning and ending balances for allowable long-term liabilities, calculated pursuant to 114.2 CMR 4.06.

Base Year. The calendar year or portion of the calendar year that is used to compute the prospective rates as defined in 114.2 CMR 4.04.

Building. The structure that houses Residents. Building costs include the direct cost of construction of the shell and expenditures for service Equipment and fixtures such as elevators, plumbing, and electrical fixtures that are made a permanent part of the structure. Building Costs also include the cost of bringing the Building to productive use, such as permits, engineering and architect’s fees, and certain legal fees. Building Costs include

interest paid during construction but not Mortgage Acquisition Costs. When the fixed assets of a facility are sold, the allowable book value of all Improvements will become part of the allowable basis of the Building for the buyer.

Change of Ownership. A bona fide transfer, for reasonable consideration, of all the powers and indicia of ownership. A Change of Ownership may not occur between Related Parties and must be a sale of assets of the facility rather than a method of financing. A change in the legal form of the Provider does not constitute a Change of Ownership unless the other criteria are met.

Community Support Facility. A facility licensed by the Department of Public Health in compliance with 105 CMR 150.000 (Licensing of Long-Term Care Facilities) that provides or makes arrangements to provide appropriate mental health services in addition to the minimum basic care and services required by 105 CMR 150.000 for Residents who do not routinely require nursing or other medically-related services.

Community Support Resident. An individual in need of Resident Care Facility services, who is 50 years of age or older and who, upon the written consent of the individual (if he or she is competent to give such consent), or guardian (if he or she is not competent) and a physical evaluation by a psychiatrist or other physician and a psychiatric evaluation by a psychiatrist, is deemed appropriate by both for residency and services provided by a Community Support Facility pursuant to 105 CMR 150.000 et seq. or its most recent applicable regulation. Any exceptions and additional factors used in determining whether a Resident is a Community Support Facility Resident shall be in accordance with 105 CMR 150.000.

Community Support Resident Days. The number of days of occupancy by Community Support Residents in a Community Support Facility and/or a Resident Care Facility with Community Support Residents. Community Support Resident Days include the day of admission but not the day of discharge. Where admission and discharge occur on the same day, one Community Support Resident day will be used. Those days a bed is held vacant for a publicly-aided Community Support Resident temporarily placed in a different care situation, pursuant to an agreement between the Provider and the Department of Transitional Assistance in accordance with duly established policies of said Department, are included as Community Support Resident Days. Those days a bed is held vacant for a non-publicly-aided Resident, whether or not there is a charge for such reservation by the facility, are included as Community Support Resident Days.

Constructed Bed Capacity. A Resident Care Facility's "Bed Capacity (or Clinical Bed Capacity)" as defined in Department of Public Health regulation 105 CMR 100.020, which states: the capacity of a Building to accommodate a bed and the necessary physical appurtenances in accordance with the applicable standards imposed as a condition of operation under state law. It shall include a room designed or able to accommodate a bed and necessary physical appurtenances, whether or not a bed and all such appurtenances are actually in place, with any necessary utilities (e.g. drinking water, sprinkler lines, oxygen, electric current, electric signals, etc.), with either outlets or capped lines within the room.

Deferred Charges. Expenditures, such as prepaid insurance, rent or licenses, not recognized as a cost of operations for the period in which they were incurred but carried forward to be written off in one or more future periods. Deferred charges are not expenditures that can be identified with and justified as relating to physical assets that will contribute services to future operations.

Department. The Massachusetts Department of Public Health.

Desk Audit. A comprehensive audit performed at the Division's offices in which the auditor evaluates the accuracy of the information in the Cost Reports and supporting documentation in accordance with an audit program.

Direct Restorative Therapy. Services of physical therapists, occupational therapists, and speech, hearing and language therapists provided directly to individual Residents to reduce physical or mental disability and to restore the Resident to maximum functional level. Direct Restorative Therapy Services are provided only upon written order of a physician, physician assistant or nurse practitioner who has indicated anticipated goals and frequency of treatment to the individual Resident.

Division. The Division of Health Care Finance and Policy established under M.G.L. c. 118G.

Equipment. Tangible fixed asset units, usually moveable, that are accessory or supplemental to such larger items as Buildings and structures.

Exit Conference. A conference conducted at the close of an on-site Field Audit at which Division auditors present audit findings and recommendations to the Provider. The Provider may respond to the Division's findings and may present additional information for review. The conference may take place at a scheduled meeting or by telephone.

Field Audit. An audit performed on-site at the Resident Care Facility in which the auditor evaluates the accuracy of the information in the Cost Reports and claim for reimbursement by examining the books and records of the facility by evaluating internal controls, observing the physical plant, and interviewing Resident Care Facility staff.

Fixed Costs. Indirect Resident care costs, independent of the level of occupancy, including interest associated with long-term debt; depreciation of Buildings; Building Improvements, Equipment and software; Equipment; insurance on Buildings and Equipment; real estate taxes; rent; the non-income related portion of the Massachusetts Corporate Excise Tax; personal property tax; and Equipment rental.

Generally Available Employee Benefits. The employee benefits that are reasonable and necessary for the efficient operation of the facility, including but not limited to insurance, pensions, bonuses, child care and non-required but job related education. Such benefits must be nondiscriminatory and available to all full-time employees.

Improvements. Expenditures that increase the quality of the existing Building by rearranging the Building layout or substituting improved components for old components so that facilities are in some way better than before the renovation. Improvements do not add to the existing Building nor do they expand the square footage of the Building. An improvement is measured by the facility's increased productivity, greater capacity or longer life.

Imputed Value. An alternative cost based on a standard amount to be used by the Division in lieu of other costs.

Indirect Restorative Therapy. Services of physical therapists, occupational therapists, and speech, hearing and language therapists to provide orientation programs for aides and assistants, in-service training to staff, and consultation and planning for continuing care after discharge.

Land. The purchase price plus the cost of bringing Land to productive use including, but not limited to, commissions to agents, attorneys fees, demolition of Buildings, clearing and grading, site-survey, soil investigation, streets, off-site sewer and water lines, and public utility charges necessary to service the Land. Land must be necessary for the care of Publicly-Aided Residents.

Licensed Bed Capacity. A Resident Care Facility's "Licensed Bed Capacity" as defined by Department of Public Health regulation 105 CMR 100.020, which states: the portion of bed capacity, by number of beds, which a Provider under its license, as issued or subsequently modified, is authorized to use for Resident care occupancy, or in the case of a facility operated by a government agency, the number of beds approved by the Department.

Limited Life Assets. Tangible fixed assets acquired after December 31, 1996 that while providing a benefit to residents in more than one reporting period, can be reasonably expected to have a useful life of less than four years. Limited Life Assets are limited to software, wallpaper and painting.

Long-Term Interest Expense. The reasonable and necessary expense incurred for the use of legitimate loans related to the care of Publicly-Aided Residents provided that the loan is supported by allowable, depreciable fixed assets. It includes all of the costs of borrowing money, including, but not limited to, interest, allowable mortgage acquisition fees, and mortgage insurance premiums.

Major Additions. A newly constructed addition to a facility that increases the Licensed Bed Capacity of the facility by 50% or more.

Massachusetts Corporate Excise Tax. Those taxes that have been paid to the Massachusetts Department of Revenue in connection with the filing of Form 355A, Massachusetts Corporate Excise Tax Return.

Maximum Available Bed Days. The total number of Licensed Bed Days for the calendar year, determined by multiplying the Mean Licensed Bed Capacity for the calendar year by the days in the calendar year.

Mean Licensed Bed Capacity. A facility's weighted average Licensed Bed Capacity for the calendar year. The value is calculated by multiplying the Licensed Bed capacity by the number of days in the calendar year for which the facility was licensed to determine the Maximum Available Bed-Days. The Maximum Available Bed-Days is divided by the number of days in the calendar year to determine the Mean Licensed Bed Capacity.

Mortgage Acquisition Costs. Those costs (such as finder's fees, points, certain legal fees, and filing fees) that are necessary to obtain long-term financing through a mortgage, bond or other long-term debt instrument.

Non-Profit Provider. A Provider either organized for charitable purposes or recognized as a non-profit entity by the Internal Revenue Service. It includes Massachusetts corporations organized under M.G.L. c. 180; clubs, associations, organizations, or entities tax-exempt; Corporations organized under M.G.L. c. 156B granted a 501(c)(3) tax exemption; and facilities owned or operated by governmental units.

Nursing Facility. A nursing or convalescent home, infirmary maintained in a town, or charitable home for the aged, as defined in M.G.L. c. 111, 71, or a Nursing Facility operating under a hospital license issued by the Department pursuant to M.G.L. c. 111, and certified by

the Department for participation in the State Medical Assistance Program, or facilities licensed to operate a Residential Care Unit within a Nursing Facility.

Permanent Factor for Interest. The Division will reimburse interest on allowable debt to the extent that such debt is supported by depreciable fixed assets. Land and Mortgage Acquisition Costs are not depreciable fixed assets. The Division will calculate the percentage of allowable debt to total debt by dividing the allowable basis of depreciable fixed assets by the total amount of the debt.

Personnel. The following Personnel are defined in accordance with 105 CMR 150.000 (Licensing of Long Term Care Facilities): Registered Nurse; Licensed Practical Nurse; Nurses' Aide, Nurse Assistants or Orderlies; Responsible Person; and Administrator.

Projected Rate. A prospective rate computed on the basis of budgetary submissions for facilities for which no historical cost data are available.

Proprietary Provider. A Provider that does not meet the criteria specified in the definition of "Non-Profit Provider."

Proposed Rates. Rates calculated by the Division that are sent to the Provider for review before certification pursuant to 114.2 CMR 4.13(1).

Provider. A Resident Care Facility providing care to Publicly-Aided Residents.

Prudent Buyer Concept. The assumption that a purchase price that exceeds the market price for a supply or service is an unreasonable cost.

Publicly-Aided Residents. A person for whom care in a Resident Care Facility the Commonwealth or a political subdivision of the Commonwealth is in whole or in part financially liable.

Rate Year. The period in which the prospective rate is in effect.

Related Party. A individual or organization associated or affiliated with, or that has control of, or is controlled by, the Provider; or any director, stockholder, trustee, partner or administrator of the Provider by common ownership or control or in a manner specified in sections 267(b), 267(c) and 318 of the Internal Revenue Code of 1954 as amended provided, however, that 10% must be the operative factor as set out in sections 267(b)(2) and (3). Related individuals include spouses, parents, children, spouses of children, grandchildren, siblings, fathers-in-law, mothers-in-law, brothers-in-law, and sisters-in-law.

Resident. Definitions set out in 105 CMR 150.000 or its most recent applicable regulation shall apply.

Resident Care Facility. A facility licensed by the Department of Public Health in compliance with 105 CMR 150.000 providing protective supervision in addition to the minimum basic care required by 105 CMR 150.000 for Residents who do not routinely require nursing or other medically-related services.

Resident Days. The number of days of occupancy by Residents in a facility. Included in the computation of Resident Days is the day of admission but not the day of discharge. Where admission and discharge occur on the same day, one Resident day is used. Those days in

which a bed is held vacant and reserved for a publicly-aided Resident temporarily placed in a different care situation, are included as Resident Days. Those days on which a bed is held vacant and reserved for a non-publicly-aided Resident, whether or not there is a charge for such reservation by the facility, are included as Resident Days.

Responsible Person. A person 21 years of age or older who has received a high school diploma, is of good moral character and has the ability to communicate orally and in writing in English, or the primary language used by Residents of the facility, and who will make mature and accurate judgments regarding the care needs of the Residents as required by 105 CMR 150.000.

Sole Proprietor. A business enterprise other than a corporation or partnership in which the net worth belongs entirely to one individual.

Support Service Coordinator. A person who has received a BA or BS degree in a human service field of study such as Psychology, Nursing or Social Work and who is employed by a Community Support Facility to identify, monitor and meet the support service needs of Community Support Residents.

Support Services. Those services provided for the benefit of Community Support Resident(s) in order to enhance psycho-social and physical functioning as defined by the Department of Public Health in 105 CMR 150.00.

Unit. Unit shall have the same definition as 150 CMR 105.000 (Licensing of Long-Term Care Facilities).

4.03: Reporting Requirements

(1) Required Reports.

(a) Resident Care Facility Cost Report. Each Provider must complete and file a Residential Care Cost Report each calendar year, containing the facility's claim for reimbursement and the complete financial condition of the facility, including all applicable management company, central office, and real estate expenses.

(b) Realty Company Cost Report. A Provider that does not own the real property of the Resident Care Facility, and pays rent to an affiliated or non-affiliated realty trust or other business entity, must file or cause to be filed a realty company Cost Report. If no report is filed, the Division will not reimburse the costs associated with the Provider's rental expense.

(c) Management Company Cost Report. A Provider that claims management or central office expenses must file a separate management company Cost Report for each entity for which it claims management or central office expense. If these costs are claimed for reimbursement, the Provider must certify that costs are reasonable and necessary for the care of Publicly-Aided Residents in Massachusetts.

(2) General Cost Reporting Requirements.

(a) Accrual Method. Providers must complete all required reports using the accrual method of accounting.

(b) Documentation of Reported Costs. Providers must maintain accurate, detailed, and original financial records to substantiate reported costs for a period of at least five years following the submission of required reports or

until the final resolution of any appeal involving a rate for the period covered by the report, whichever occurs later. Providers must maintain complete documentation of all of the financial transactions and census activity of the facility and affiliated entities, including but not limited to the books, invoices, bank statements, canceled checks, payroll records, governmental filings and any other records necessary to document the Provider's claim for reimbursement. Providers must be able to document expenses relating to affiliated entities for which reimbursement is claimed whether or not they are Related Parties.

(c) Fixed Asset Ledger. Providers must maintain a fixed asset ledger that clearly identifies each asset for which reimbursement is being claimed, including its location, the date of purchase, the cost, salvage value, accumulated depreciation, and the disposition of sold, lost or fully depreciated assets.

(d) Job Descriptions and Time Records. Providers and management companies must maintain written job descriptions including time records, qualifications, duties, and responsibilities for all positions for which reimbursement is claimed. The Division will not reimburse the salary and fringe benefits or the imputed amount for Sole Proprietors as specified in 114.2 CMR 4.05(3) for any individual for which the Provider does not maintain a job description and time record.

(e) Other Cost Reporting Requirements.

1. Expenses that Generate Income. Providers must identify the expense accounts that generate income. The Division will offset reported ancillary income if the Provider does not identify the associated expense account.

2. Laundry Expense. Providers must separately identify the expense associated with laundry services not provided to all Residents. Providers may not claim reimbursement for such expense.

3. Fixed Costs.

a. Providers must allocate all Fixed Costs, except Equipment, on the basis of square footage. Providers may elect to specifically identify Equipment related to the Resident Care Facility. The Provider must document each piece of Equipment in the fixed asset ledger. If a Provider elects not to identify Equipment, it must allocate Equipment on the basis of square footage.

b. If a Provider undertakes construction to replace beds, it must write off the fixed assets that are no longer used to provide care to Publicly-Aided Residents and may not claim reimbursement for the assets.

c. Providers must separately identify fully depreciated assets. Providers must report the costs of fully depreciated assets and related accumulated depreciation on all reports unless they have removed such costs and accumulated depreciation from the Provider's books and records. Providers must attach to the Cost Report a schedule of the cost of the retired Equipment, accumulated depreciation and the accounting entries on the books and records of the facility when the Equipment is retired.

d. Providers may not report expenditures for major repair projects whose useful life is greater than one year as expenses.

Providers must not report such expenditures as pre-paid expenses.

4. Mortgage Acquisition Costs. Providers must classify Mortgage Acquisition Costs as other Assets. Providers may not add Mortgage Acquisition Costs to fixed asset accounts.

5. Related Parties. Providers must report salary expenses paid to a Related Party and must identify all goods and services purchased from a Related Party. If a Provider purchases goods and services from a Related Party, it must disclose the Related Party's cost of the goods and services. The Division will limit reimbursement for such goods and services to the lower of the Related Party's cost or the Prudent Buyers Concept.

6. Service of Non Paid Workers. The services must be fully disclosed in the Footnotes and Explanations section of the Cost Report. Both the total Expense and the account(s) in which the expense is reported must be identified.

7. Facilities in which other programs are operated. If a Provider operates an adult day health program, an assisted living program, or provides outpatient services, the Provider must not claim reimbursement for the expenses of such programs. If the Provider converts a portion of the facility to another program, the Provider must:

a. identify existing Equipment no longer used in Resident Care Facility operations. Such Equipment must be removed from the facility's records;

b. identify the square footage of the existing Building and improvement costs associated with the program, and the Equipment associated with the program; and

c. allocate shared costs, including shared capital costs, using a well documented and generally accepted allocation method. The Provider must directly assign to the program any additional capital expenditures associated with the program.

(3) Filing Deadlines.

(a) General. All Resident Care Facilities must file required Cost Reports for the calendar year by 5:00 P.M. May 1 of the following calendar year. If May 1 falls on a weekend or holiday, the reports are due by 5:00 p.m. of the following business day.

(b) Special Provisions.

1. Change of Ownership. The transferor must file Cost Reports within 60 days after a Change of Ownership. The Division will notify the Department of Transitional Assistance if required reports are not filed timely for payments to be withheld or other appropriate action by that agency.

2. New Facilities and Facilities with Major Additions. New Facilities and facilities with Major Additions that become operational during the Rate Year must file year end Cost Reports within 60 days after the close of the first and second Rate Years.

3. Appointment of a Resident Protector Receiver. If a receiver is appointed pursuant to M.G.L. c. 111, s. 72N, the Provider must file Cost Reports for the pre-receivership reporting period or portion thereof, within 60 days of the receiver's appointment.

(c) Extension of Filing Date. The Director of the Health Data Policy Group may grant a request for an extension of the filing due date for a maximum of 45 calendar days. In order to receive an extension, the Provider must:

1. submit the request itself. Agents or other representatives may not request extensions.
2. demonstrate exceptional circumstances that prevent the Provider from meeting the deadline; and
3. file the request no later than 15 calendar days before the due date.

(4) Incomplete Submissions. If the Cost Reports are incomplete, the Division will notify the Provider in writing within 120 days of the receipt. The Division will specify the additional information that the Provider must submit to complete the Cost Reports. The Provider must file the necessary information within 25 days of the date of notification or by May 1 of the year the Cost Reports are filed, whichever is later. If the Division fails to notify the Provider within the 120-day period, the Cost Reports will be considered complete and deemed to be filed on the date of receipt.

(5) Amended Reports. Amended Reports will be accepted no later than August 15 of the year in which the cost reports are due. Amended Reports must be accompanied by a complete list of the corrections made to the reports with sufficient supporting documentation along with an explanation of the reasons therefore.

(6) Additional Information. The Division may require the Provider to submit additional data and documentation during a Desk or Field Audit even if the Division has accepted the Provider's Cost Reports. In addition, the Division may request additional information and data relating to the operations of the Provider and any Related Party.

(7) Failure to File Timely.

(a) If the Provider does not file the required cost reports by the due date, the Division may reduce the Provider's rate for current services by 5% on the day following the date the submission is due and 5% for each month of noncompliance thereafter. The reduction accrues cumulatively such that the rate reduction equals 5% for the first month late, 10% for the second month late, and so on. The rate will be restored effective on the date the Cost Reports are filed.

(b) The Division may, at its discretion, limit the imposition of the late filing sanction in 114.2 CMR 4.03(7).

4.04: Principles for Determining Prospective Rates of Payment

(1) Prospective Per Diem Rate Methodology.

(a) General. Except for new facilities and facilities with Major Additions, as specified in 114.2 CMR 4.10, the Division will calculate prospective rates for each Provider based upon the Provider's Base Year costs.

(b) Cost Centers. The Division will calculate the Provider's rates by summing the allowable per diem amount for each separate Cost Center. The methodology for computing the allowable per diem for each Cost Center is set forth in the following sections:

Variable Cost Allowance	114.2 CMR 4.05
Capital and Other Fixed Costs	114.2 CMR 4.04, 4.07, 4.08 and 4.09
Equity Allowance	114.2 CMR 4.08
Use and Occupancy Allowance	114.2 CMR 4.08
Total Payment Adjustment	114.2 CMR 4.04(11)

(2) Base Year. Except as provided below, the Base Year for Rate Year 2006 rates is 2002.

(a) New Facilities and Major Additions. The Division will calculate rates for facilities with no Base Year cost history, including New Facilities, Facilities with Major Additions, and Non-Nursing facilities that convert to Resident Care Facilities pursuant to 114.2 CMR 4.10.

(b) Facilities sold during the Base Year. If a facility was sold during the Base Year, the Division will use the buyer's Cost Reports for the buyer's period of ownership to determine allowable Base Year costs, unless the Director concludes that the buyer's period of ownership was not long enough to ensure that it is representative of annualized costs. The calculation of allowable Fixed Costs and the Average Equity Capital Allowance or Use and Occupancy Allowance, as appropriate, is based on the Report(s) filed by the transferee.

(c) Facilities that closed after the Base Year. If a facility closed after the Base Year and subsequently reopened, the Division will use the Base Year Cost Reports to calculate the rate. If no Base Year Cost Reports were filed, the Division will use the latest Cost Reports for the facility filed prior to the Base Year. In such cases, the Division will increase the Variable Cost Allowance by an appropriate Cost Adjustment Factor.

(d) Private Resident Care Facilities. If a Resident Care Facility that was a private facility in the Base Year, timely filed a Base Year Cost Report, and signed a Provider agreement to provide services to Publicly-Aided Residents in the Rate Year, the Division will use that Base Year Cost Report to calculate rates pursuant to the methodology set forth in 114.2 CMR 4.04-4.09. If such a facility did not file a Base Year Cost Report, the Provider must file a Base Year Cost Report in order for the Division to compute the rates. Resident Care Facilities that were private during a Base Year are not subject to the late filing sanctions under 114.2 CMR 4.03(7) for the Base Year Cost Report.

(e) Facilities Purchased from a Receiver. Upon the sale of a facility in receivership, the Division may use a different Base Year Cost Report if the new owner demonstrates that a different Base Year more accurately reflects the reasonable and necessary costs of providing adequate Resident care and if the Department and Department of Transitional Assistance approve such treatment. In such cases, the Division will increase the Variable Cost Allowance by an appropriate cost adjustment factor.

(f) Rates for Innovative and Special Programs. The Division may include an allowance for costs and expenses to establish and maintain an innovative program for providing care to Publicly-Aided Residents if the Provider:

1. has received prior written approval from the Department of Elder Affairs to establish and maintain a program; or
2. participates in a special program pursuant to a contract with the Department of Transitional Assistance under which specific homes may contract to accept Residents designated by that agency.
3. develops and implements on an experimental basis, innovative incentive reimbursement systems. Any reimbursement system under 114.2 CMR 4.12 must be consistent with the standards of the Department and cannot be initiated without prior written approval from the Division.

(3) Facilities Converting to Assisted Living Programs. For facilities that are identified, in writing, by the Department of Transitional Assistance for treatment under this provision, the Division will undertake any and all rate development and certification action as deemed necessary and appropriate after consultation with the Department of Transitional Assistance.

(4) Divisors. The divisors used are:

(a) Variable Cost Allowance. This divisor is the greater of Base Year Resident care days or 94% of the Mean Licensed Bed Capacity in the Base Year times the days in the Base Year.

(b) Fixed Costs, Equity and Use and Occupancy. This divisor is the Constructed Bed Capacity times the days in the Rate Year times the greater of 94% or the Actual Utilization Rate in the Base Year.

(5) Cost Adjustment Factor. The Cost Adjustment Factor, applied to the Variable Cost Allowance is 8.43%. If there has been a Change of Ownership in the Base Year, and the rates are based on the new owner's reported Base Year costs, the Division will modify the Cost Adjustment Factor to reflect the number of months from the midpoint of the new owner's reporting period to the midpoint of the prospective rate period.

(6) Audits. The Division will establish rates after a comprehensive Desk Audit of the Base Year Cost Report. The Division will also, whenever possible, conduct on-site Field Audits to ensure the accuracy of the claims for reimbursement and consistency in reporting. During such audits, auditors will gather and evaluate evidence that they deem necessary to evaluate the Provider's claim for reimbursement. The Division will disallow any cost for which the Provider does not produce adequate documentation requested by the Division during a Desk or Field Audit.

(7) General Cost Principles. In order to be reimbursed, a cost must:

(a) be ordinary, necessary and directly related to the care of Publicly-Aided Residents;

(b) adhere to the Prudent Buyer Concept;

(c) be for goods and services actually provided in the Resident Care Facility;

(d) not have the transaction effect of circumventing these rules under the principle that the substance of the transaction must prevail over form;

(e) actually be paid by the Provider. Examples of costs that are not considered paid for purposes of reimbursement include, but are not limited to costs that are: discharged in bankruptcy; forgiven; converted to a promissory note; and accruals of self-insured costs based on actuarial estimates; and

(f) not be paid to a Related Party that has not been identified on the Reports.

(8) Non-Allowable Costs. Rates will not include those costs that are not reimbursable, as defined below, are reimbursed through an allowance, or are for services that are billed directly.

(a) Costs that are not reimbursable.

1. Bad debts, refunds, charity and courtesy allowances and contractual adjustments to the Commonwealth and other third parties;

2. Recovery of expense items, that is, expenses that are reduced or eliminated by applicable income including but not limited to, rental of quarters to employees and others, income from meals sold to persons other than Residents, telephone income, vending machine income and

medical records income. Vending machine income will be recovered against the Variable Cost, included in the Variable Cost Allowance.
3. Federal and state income taxes, except the non-income related portion of the Massachusetts Corporate Excise Tax;
4. Expenses that are not directly related to the provision of Resident care including, but not limited to, expenses related to other business activities and fund raising, gift shop expenses, research expenses, rental expense for space not required by the Department and expenditure of funds received under federal grants for compensation paid for training personnel, and expenses related to grants or contracts for special projects;
5. Compensation and fringe benefits for Residents on a Provider's payroll;
6. Any amounts in excess of any schedule or limitation contained in 114.2 CMR 4.00;
7. Penalties and interest, incurred because of late payment of loans or other indebtedness, late filing of federal and state tax returns, or from late payment of municipal taxes;
8. Any increase in compensation or fringe benefits granted as an unfair labor practice after a final adjudication by the court of last resort.
9. Accrued expenses that remain unpaid more than 120 days after the close of the reporting year, excluding vacation and sick time accruals, are not included in the prospective rates. When the Division receives satisfactory evidence of payment, the Division may reverse the adjustment and include that cost, if otherwise allowable, in the applicable prospective rates. Except as provided above, a cost must actually be paid by the Provider in order to be reimbursable. Examples of costs that are not considered paid for purposes of reimbursement include, but are not limited to costs that are discharged in bankruptcy; costs that are forgiven; costs that are converted to a promissory note; and accruals of self-insured costs that are based on actuarial estimates.
10. Expenses for Purchased Service Nursing services purchased from temporary nursing agencies that are not registered with the Department under regulation 105 CMR 157.000;
11. Any expense or amortization of a capitalized cost relating to costs incurred prior to the opening of the facility;
12. Expenses relating to the financing of or otherwise supporting political or lobbying activities regarding legislation to affect reimbursement methods; campaign contributions; and advertising to create goodwill or otherwise affect payments made by governmental units.
13. All legal expenses; and those accounting expenses and filing fees associated with any appeal process.
14. Additional rental payments or charges based upon receipts or income will not be considered as additional rental expense.
15. Interest payments and charges based upon the Provider's receipts or income will not be considered as allowable interest expense.
16. Any costs that were incurred in periods other than the Base Year.
17. Recovery of rates charged to private residents in the Base Year that are less than the public rates certified in the corresponding Base Year, including any public rates that would be affected by a legal settlement or appeal. The Division will multiply the difference

between the Base Year rate for publicly-assisted residents and the average rate charged private residents corresponding to the Base Year above. [(Private income / resident private patient days = private rate per diem) – (public Base Year Rate per Diem) = per diem difference] x (base year resident private patient days /Base Year patient days = the amount per diem that the publicly aided rate will be reduced.) In no instances will the certified rate be lower than the lowest private rate assigned to an individual for that period.

(b) Costs reimbursed through an allowance or other specified methodology.

1. Other recoverable income will be recovered against an account in the appropriate cost group category, such as Variable Cost Allowance and Fixed Costs.
2. Interest on short-term or working capital obligations is not allowed, but will be reimbursed pursuant to the Working Capital Allowance (114.2 CMR 4.07 (1)(a));
3. Any costs, including rental and leasehold expenses, for Buildings and Equipment that are not located at the site of the Resident Care Facility will not be allowable as Fixed Costs.

(c) Costs for services billed directly. The following supplies or services must be billed directly to the purchaser in accordance with the purchaser's regulations or policies.

1. Physician. Direct physician services to individual Residents, including emergency physician services required by 105 CMR 150.000:
2. Medical Supplies. Direct medical services or supplies in accordance with the regulations or written policy of the governmental unit responsible for paying for such services or supplies in the per diem rates.
3. Prescriptions. Pharmacy costs related to legend drug prescriptions and prescribed legend drugs for individual Residents;
4. Therapy. Direct restorative services provided upon written order of a physician.
5. Ancillary Services. The Division may include ancillary services and supplies in the rates in accordance with the regulations or written policy of the purchasing agency.

(9) Capital and Other Allowable Fixed Costs. The Division will calculate total allowable Fixed Costs by adding the allowable portion of depreciation, long-term interest, real estate taxes, personal property taxes on the Resident Care Facility equipment, the non-income portion of the Massachusetts Corporate Excise Tax, building insurance, and rental of equipment located at the facility.

(10) Rental and Leasehold Expense. The Division will allow reasonable rental and leasehold expenses for Land, Building and Equipment, but reimbursement is limited to the lower of: average rental or ownership costs of comparable Providers, or the reasonable and necessary costs of the Provider and lessor including interest, depreciation, real property taxes and property insurance. The Division will not allow rent and leasehold expense unless a Realty Company Cost Report is filed.

(11) Total Payment Adjustment. There is an additional adjustment to reflect the percentage change between the facility's rate in effect on September 30, 2005 and the October 1, 2005 preliminary rate. The preliminary rate equals the sum of the Variable Cost Allowance adjusted by the cost adjustment factor, Capital and Other

Fixed Costs, Equity Allowance, Working Capital Allowance, and Use and Occupancy Allowance.

(a) If the percentage increase between a facility's September 30, 2005 rate and the preliminary October 1, 2005 rate is less than 0%, the Total Payment Adjustment will equal the difference between the September 30, 2005 rate and the preliminary October 1, 2005 rate.

(b) If the percentage increase between a facility's September 30, 2005 rate and the preliminary October 1, 2005 rate is greater than 0% but less than 5%, the facility will receive no Total Payment Adjustment.

(c) If the percentage increase between a facility's September 30, 2005 rate and the preliminary October 1, 2005 rate is greater than 5%, the Total Payment Adjustment will equal the difference between 105% of the facility's September 30, 2005 rate minus the preliminary October 1, 2005 rate.

(12) Annualization Adjustment. Resident care facilities will receive an additional, one-time adjustment to annualize all rate increases with an October 1, 2005 effective date. This adjustment will expire effective July 1, 2006. The Division may recertify the rates effective July 1, 2006 to eliminate the adjustment in rates effective on or after July 1, 2006. The annualization adjustment is 33.34% of the difference between the preliminary October 1, 2005 rate, including the Total Payment Adjustment as described in 114.2 CMR 4.04(11) and excluding any administrative adjustments made pursuant to 112.2 CMR 4.11, and the September 30, 2005 rate.

4.05: Variable Cost Allowance

(1) Scope. The Division will include in each Provider's rate a Variable Cost Allowance to compensate for Variable Costs. The Variable Cost Allowance includes the allowable amounts reported in the following accounts from the Cost Report: Administrator/Responsible Person Salaries and Benefits; Clerical Salaries; EDP/Payroll/Bookkeeping Services; Office Supplies; Telephone, except directory advertising; Advertising, Help Wanted; Licenses and Dues, Resident Care Related; Total Education and Training; Total Employee Benefits except Officers, Profit Sharing and Other Benefits; Accounting Services not related to Appeals; Total Payroll Taxes, except officer; Non-Profit DES Claims; Malpractice and General Liability Insurance; Total Workers' Compensation except officer; Total Group Life/Health except officer; Total Plant Operations; Total Dietary; Total Laundry; Total Housekeeping; Total Nursing; Quality Assurance Professional; Community Support Coordinator; Total Physician Services; House Supplies, not resold; Pharmacy Consultant; Social Service Worker; Indirect Therapy Salaries; Indirect Therapy Consultants; Total Recreation, except transportation; Realty Company Variable Add-Back; Management Company Variable and Fixed Cost Add-Back; Less Non-Allowable Self Disallowances, Vending Machine Income, and Other Operating Cost Recoverable Income. The Variable Cost Allowance also includes the allowable amounts reported in the Motor Vehicle Expenses and Conventions and Meetings Expenses accounts from the Cost Report.

(2) Limitation. The maximum amount for allowable variable costs is $70.42.

(3) Base Year Variable Cost. The Division will calculate the Base Year Variable Cost per diem for each Provider by dividing the total Allowable Base Year Variable Costs by the Divisor stated in 4.04(4)(a). For providers that are organized as Sole Proprietors, the Division will include an imputed amount of $29,100 for the personal services of an owner.

(4) Allowable Variable Cost Allowance. The Allowable Variable Cost Allowance will be calculated as follows:

(a) The Variable Cost Allowance equals the lower of the Base Year Variable Cost per diem or $70.42.

(b) The Allowable Variable Cost Allowance equals the Variable Cost Allowance adjusted by the Cost Adjustment Factor.

(5) Special Provisions.

(a) Accrued Expenses. The Division will not allow accrued expenses that remain unpaid for more than 120 days after the close of the reporting year, excluding vacation and sick time accruals. If the Provider submits evidence of satisfactory payment, the Division may reverse the adjustment and include that cost, if otherwise allowable, in the applicable rates.

(b) Accounting and Auditing Expenses. Reasonable and necessary accounting and auditing expenses in matters directly related to providing adequate care to Publicly-Aided Residents are included, provided that the books and records of the Provider are maintained in accordance with generally-accepted accounting principles.

(c) Staff Training Expenses. The net cost, which is the cost of required staff training activities less any reimbursement from grants, tuition, specific donations, employee contributions, or other sources is included, only if the training is:

1. conducted within the Commonwealth of Massachusetts;
2. directly related to improving Resident care to Publicly-Aided Residents; and
3. conducted by a recognized school, other authorized organization or a qualified professional as required in 105 CMR 150.00.

(d) Advertising Expenses. The reasonable and necessary expense of newspaper or other public media advertisements for the purpose of securing necessary employees.

(e) Generally Available Employee Benefits. The extent of the facility's contribution to the cost of generally-available fringe benefits are included so long as they are non-discriminatory.

(f) Membership Dues. Reasonable and necessary membership dues are included if the organization's function and purpose are directly related to the development and operation of the facility and providing adequate Resident care.

(g) Services of Non-Paid Workers. Services performed under an agreement between the organization and the Provider for the performance of the services without direct payment. The value of services normally provided on a voluntary basis, such as distribution of magazines and newspapers to Residents, does not constitute a reasonable variable cost. The net value of services for non-paid persons in positions customarily held by paid employees, performing such services on a regular basis as non-paid members of religious or other organizations, is allowable as a variable cost if:

1. The amount allowed shall not exceed that which would be paid others for similar work;
2. The amount paid by the Provider to the organization must be identifiable in the records of the Provider as a legal obligation; and
3. The services must be performed on a regular, scheduled basis and must be necessary for the provision of adequate Resident care to Publicly-Aided Residents and for the efficient operation of the Provider.

(h) Non-Legend Drugs. The reasonable and necessary costs of providing the non-legend drugs listed in the Department's Circular Letter (LTCFP): 1-75-71, including those non-legend drugs ordered by a doctor. Non-legend drugs must not be billed directly to any governmental unit or charged against the personal care funds of any Resident.

(i) Pension Plans. Reasonable and necessary expenses incurred by a Provider relating to a pension plan are included as a Generally Available Employee Benefit subject to all of the provisions of the regulation. Reimbursable pension plans must provide for either a fixed determinable amount to be contributed by the employer on a regular basis or for a fixed determinable benefit to be received by the employee at retirement. Reimbursement of pension costs are subject to the following specific provisions:

1. Required by State Statute. Providers required by enabling statute to make payments to municipal or county pension funds will be reimbursed for the compensation paid by the plan, provided that the detail of the allocations provided to the Public Employees Retirement Administration is submitted to the Division and that in the case of a funded pension plan a schedule of the individuals associated with the Resident Care Facility are also submitted.

2. Not Required by State Statute. Providers not required by state statute to make payments to a municipal pension fund will be reimbursed for expenses incurred to the extent that:

a. the claimed expenses represent an amount based on fair, reasonable and necessary compensation for services performed by employees and

b. the claimed expenses are costs incurred on current year payroll and do not include payments for prior year payroll and

c. the plan does not provide for contributions by the employer based on the contingency of profit or is at the discretion of the employer and

d. the pension plan must have met the current requirements of and, if applicable, received the approval of the Internal Revenue Service. All applicable Internal Revenue Service forms documenting Internal Revenue Service approval must be filed with the Division along with copies of the plan and

e. the employer's contribution to a pension plan will be included, along with other increments in the calculation of limits to the reimbursement of individual employee compensation as referred to in 114.2 CMR 4.00 and

f. any forfeiture by an employee must be applied against the cost to reduce the premiums paid by the employer. A forfeiture shall be considered to have occurred when any employee who participated in the pension plan terminates employment prior to becoming vested. This reduction in the claim for reimbursement shall be made notwithstanding the terms or lack of terms in the pension plan.

4.06: Average Equity Capital

(1) Calculation of Average Equity Capital Allowance.

(a) Rate Adjustment for Average Equity Capital. The per diem rate of a Proprietary Provider that has a positive equity position shall be increased by an annually-determined multiplier of the Average Equity Capital divided by a divisor as described in 114.2 CMR 4.04(4). This annually-determined multiplier is 100% of the interest rate on special issues of public debt obligations issued to the Federal Hospital Insurance Trust Fund. The multiplier for 2006 rates is the FHITF percent effective for April 2004, which is 3.875%.

(b) Average Equity Capital. Average Equity Capital is the difference between the Provider's Allowable book value of Fixed Assets, including Land, at the beginning and end of the year as determined under 114.2 CMR 4.08-4.09, and the Provider's allowable long-term liabilities at the beginning and end of the year.

1. The Division will reduce Average Equity Capital by Building, Improvements, Equipment, and software Depreciation allowed in prior years.
2. The Division will not include Mortgage Acquisition Costs, such as capitalized legal fees and prepaid interest on long-term obligations, or equity in Buildings or Equipment not located at the Resident Care Facility, in Average Equity Capital.
3. The Division will not reduce Average Equity Capital by long-term loans for which interest has been excluded as a result of debt not supported by allowable fixed assets.
4. If a facility replaces beds, reimbursable equity will be computed again using the newly established allowable fixed assets and allowable debt.

(2) Use and Occupancy Allowance. The Division will increase Non-Profit Provider's rates to reflect the cost of use and occupancy of net allowable fixed assets. The Division will calculate this Allowance pursuant to 114.2 CMR 4.06(1) and divide by three.

4.07: Interest Expense

(1) Maximum Allowable Interest Expense. Reasonable and necessary interest expense will be included in the rate as follows:

(a) Interest on Working Capital. Interest on short term working capital is not allowable in the calculation of the prospective rates. In lieu of these costs, the Division will add an allowance for the financing of current operations to the rates, determined by multiplying the facility's rate, less Fixed Costs, return on equity and the use and occupancy allowance, by 1/12 of the annual prime lending rate. For 2006 rates, the prime lending rate, which was in effect as of June 27, 2003, is 4.00%.

(b) Interest on Long-Term Debt. The Division will include in the rates the reasonable and necessary interest on allowable long-term debt, supported by depreciable Fixed assets subject to 114.2 CMR 4.09.

1. Such interest will be limited to an annually-determined percentage of simple interest on all outstanding long-term loans weighted by the dollar amount of the funds borrowed. The annually-determined percentage will be, for allowable long-term debts secured prior to January 1, 1984, the rate as stated in the debt instrument at the time of borrowing; and, for allowable long-term debts secured on and after January 1, 1984, the lower of the rate as stated in the debt instrument

at the time of borrowing, or a percentage equal to the monthly rate of interest on special issues of public debt obligations issued to the Federal Hospital Insurance Trust Fund for the third month prior to the month in which the financing occurred plus three percent. In no event shall the rate of interest that the Division allows exceed 15% per annum.

2. The allowable interest rate, as set forth in 114.2 CMR 4.07(1)(b)1 will apply for reimbursement purposes throughout the life of any debt and continue to apply in cases where a non-recognized refinancing has occurred, as cited in 114.2 CMR 4.07(1)(b)3. The Division will not reimburse any Long-Term Interest Expenses that exceeds the allowable interest rate.

3. The Division will recognize the refinancing of an existing allowable debt as an allowable debt under the following circumstances:

a. Crossover. When the accumulated principal payments on the existing, allowable debt exceeds the accumulated depreciation allowed by the Division pursuant to 114.2 CMR 4.08 on the allowable fixed assets that have been financed by that debt; or

b. Demand Note. When an existing, allowable debt becomes payable upon demand; or

c. Lowered Expense. When, as a result of the refinancing, Long-Term Interest Expense is lower over the life of the refinancing than it would have been under the remainder of the existing, allowable debt. The Provider shall submit comparative schedules showing total Long-Term Interest Expense under both the existing, allowable debt and the re-financing;

d. Financing of Allowable Additions. When a Provider refinances for amounts greater than the existing, allowable debt on the date of the refinancing and the additional indebtedness is used for a significant addition of allowable depreciable fixed assets under 114.2 CMR 4.09. If the refinancing is for amounts greater than the existing allowable debt on the date of the refinancing and the additional indebted is used for purposes other than a significant addition of allowable depreciable fixed assets, the Division will not reimburse interest expense on the additional indebtedness.

4. The allowable interest rate for an allowable or partially allowable refinancing under 114.2 CMR 4.07(1)(b) is set forth in 114.2 CMR 4.07(1)(b)1. The allowable interest rate will apply for reimbursement purposes throughout the life of the allowable refinancing. Any Long-Term Interest Expenses that exceed the allowable interest rate will not be reimbursed.

5. When a refinancing, or a portion of a refinancing, is not allowable under the above provisions, the Division will calculate the reimbursement for Long-Term Interest Expenses as though the non-allowable refinancing did not occur. In no event will the reimbursement exceed the amount of Long-Term Interest Expenses actually incurred by the Provider.

6. In order for the interest related to the financing of newly acquired fixed assets to be considered for reimbursement the acquisition and financing should occur concurrently. However, a grace period of not

more than 90 days between the date of acquisition and financing shall be permitted in instances where the Provider can present sufficient documentation to support its claim that all reasonable attempts were made to finance the asset at the time of acquisition.

(2) Loans from Owner, Officer or Related Party. Interest expense shall not include interest on loans to the facility from an owner, officer, or Related Party.

(3) Mortgage Acquisition Costs. Mortgage Acquisition Costs must be amortized over the life of the mortgage. Amortized mortgage acquisition costs are treated as long term interest expense. For allowable long term debts secured on or after January 1, 1983, Mortgage Acquisition Costs will be subject to the provisions of maximum interest rates and permanent factors, if applicable.

4.08: Depreciation

(1) Depreciation Allowed. The Division will allow depreciation of Building and Equipment based on accepted accounting principles using as a basis the lower of the original acquisition cost of the facility, an amount based on a cost per bed for the year of construction of the facility set forth in the regulation governing the Rate Year of the original acquisition, or the principles set forth in 114.2 CMR 4.09 if a Change of Ownership occurs on and after January 1, 1984.

(2) Depreciation Methodology. The straight-line method will be used to calculate the allowances for depreciation. Upon expiration of the useful life of assets, the related depreciation will be excluded from the Base Year costs for purposes of computing the prospective rate.

(3) Useful Life. For depreciation purposes, the following will be used:

ASSET	LIFE	RATE
Building Class I or II as classified by the Dept. of Public Safety	40 yrs.	2.5%
Class III or IV as classified by the Dept. of Public Safety	33 yrs.	3.0%
Building Improvements and Leasehold Improvements	Varies	up to 5%
Equipment, Furniture and Fixtures	10 yrs.	10%
Motor Vehicle Equipment	4 yrs.	25%
Software used directly for benefit of Publicly Aided Residents	3 yrs.	33.3%
Limited Life Assets acquired after December 31, 1996	3 yrs.	33.3%

4.09: Limitation of Basis for Depreciation, Interest and Equity

(1) Allowable Basis for Fixed Assets. The basis for assets will be uniformly applied to the calculation of allowable depreciation and interest. In no case will allowable costs for depreciation and interest be calculated on a basis that exceeds the limitations of 114.2 CMR 4.10.

(a) Change of Ownership.

1. If there has been no change of ownership, the allowable basis of fixed assets will be the reasonable construction costs.

2. If the change of ownership occurred prior to January 1, 1988, the allowable basis for fixed assets will be determined pursuant to 114.2 CMR 4.00 in effect for that year.

3. If the change of ownership occurred on or after January 1, 1988, the allowable basis of fixed assets will be determined as follows:

a. Land. the lower of acquisition cost or the basis allowed the immediate prior owner;

b. Equipment. The lower of acquisition cost or the basis allowed the immediate prior owner, reduced by the amount of actual depreciation allowed to the prior owner of the facility in calculating rates of payment for Publicly-Aided Residents;

c. Building and Building Improvements. The lower of the acquisition cost or the basis allowed the immediate prior owner, reduced by the amount of actual depreciation allowed to the prior owner of the facility for publicly aided Residents for the years 1968 to the date of Change of Ownership. The sellers allowable Building Improvements will become part of the new owners allowable basis of Building.

In all transfers where the amount of actual depreciation allowed for the facility in a prior year is not known, the new owner has the burden of demonstrating the amount, otherwise the Division will reconstruct the amount using the best available information. In the case of a financing agreement between the transferor and the transferee, the agreement is constructed to effect a complete Change of Ownership and there is compliance with the terms of such agreement. The Division reserves the right to evaluate the relationship between the transferor and the transferee and monitor compliance with the agreement to assure a complete Change of Ownership.

(b) Allowable Basis. Where there has been a Change of Ownership on or after January 1, 1988, the allowable basis of previously transferred fixed assets will be determined as follows:

1. Fixed Assets. Those previously transferred subsequent to January 1, 1968 will be depreciated over their remaining useful life.

2. Building and Building Improvements (excluding Equipment). Those previously transferred prior to January 1, 1968 will be depreciated over their remaining useful life plus the number of years the assets were in the possession of the transferor prior to 1968. The sellers allowable Building Improvements will become part of the new owners allowable basis of Building.

(c) Depreciation on Assets. The annual amount of depreciation on the assets that have been transferred must not exceed that allowed to the previous owner.

(2) Forgiveness of Debt. Where, subsequent to a Change of Ownership, the transferor forgives or reduces the debt of the transferee, such forgiveness or reduction of debt shall be retroactively applied to reduce the acquisition cost to the transferee.

(3) Reasonable Construction Cost. For a newly constructed facility opening for Resident care on or after January 1, 1984, the basis of such assets will be limited to reasonable, audited construction and Equipment costs based upon the minimum standards and requirements of the Massachusetts Department of Public Safety. Once operations commence, interest and acquisition fees will be treated as a cost of borrowing and treated as interest expense. In no case shall the allowable basis exceed the cost of construction approved in accordance with M.G.L. c. 111, 25C. The basis of its assets will be limited to construction and Equipment costs based upon the minimum standards and requirements of the Massachusetts Public Health Council. The Division will reimburse only those costs associated with meeting the above-mentioned standards.

(4) Repossession by Transferor. The basis of fixed assets will be re-computed if the transferor repossesses a facility to satisfy in whole or in part the transferee's purchase obligations, becomes a direct or indirect owner, or receives an interest in the transferee's facility or company. The re-computed basis will not exceed the transferor's original allowable basis under Division regulations applicable at the date of Change of Ownership increased by any allowable capital Improvements made by the transferee since acquisition and reduced by depreciation since acquisition.

(5) Resident Care Facilities downgraded from Nursing Facilities. If a Nursing Facility downgrades to a Resident Care Facility, the allowable basis for fixed assets and equity will be the basis allowed by the Division under regulation 114.2 CMR 6.00, except that no Equity Supplement that had been included in that regulation will be carried forward into the rates of the Resident Care Facility.

4.10: New Facilities and Major Additions

(1) Projected Rates. The Division will calculate projected rates for New Facilities and Facilities with Major Additions in the Rate Year. The provider must file a projected cost report that projects the reasonably anticipated costs and anticipated Resident care days for a 12-month period commencing with the first date of licensure.

(a) New Facilities and Facilities with Major Additions becoming operational prior to July 1 of the Rate Year.

1. First Rate Year. The Division will calculate a projected rate based on the projected cost report described in 114.2 CMR 4.10(1). The effective dates of the rate will be the first date of licensure through December 31 of the first Rate Year that the facility becomes operational.
2. Second Rate Year. The Division will calculate the rate for the second Rate Year based on the projected cost report described in 114.2 CMR 4.10(1).
3. Third Rate Year. The rate for the third Rate Year is based on the first calendar year Cost Report of actual expenditures.

(b) New Facilities and Facilities with Major Additions becoming operational on or after July 1 of the Rate Year.

1. First Rate Year. The Division will calculate the rates based upon the projected cost report as described in 114.2 CMR 4.11(1). The effective dates of the rate will be the first date of licensure through December 31 of the first Rate Year that the facility becomes operational.

2. Second Rate Year. The rate for the second Rate Year is based on the same projected Cost Report that was used for the first Rate Year.

3. Third Rate Year. The Division will calculate the rate for the third Rate Year based on the Cost Report of actual expenditures filed for the second calendar year.

(c) The Division will recalculate projected rates based upon actual cost data, once a provider files a cost report(s) that covers the projected rate period.

(2) Cost Ceilings. The Division will use the Cost Reports as described in 114.2 CMR 4.10(1) subject to appropriately inflated ceilings and limitations for each cost center.

4.11: Administrative Adjustments

(1) General. A Provider may petition during the rate year for an administrative adjustment only for the circumstances set forth in 114.2 CMR 4.11(4).

(a) Petition Requirements. A petition for administrative adjustment must include: the Provider's name, address, a detailed explanation, under oath, of the basis of the petition and documentation supporting the amount requested including, but not limited to, invoices, canceled checks, loan documents, any construction contracts and the project beginning and ending dates.

(b) The petitioner must provide any other information that the Division requires within 30 days of the request. If the petitioner fails to timely provide requested information, the Division will deny the petition.

(c) The Division will suspend review of any petition if the Provider has failed to submit reports or other information required by 114.2 CMR 4.00 in a timely manner. If the Provider fails to file the required information within 60 days after notification by the Division, the Division will dismiss the petition for administrative adjustment.

(d) The Division will suspend review of any petition if the Department notifies the Provider that it has identified a quality of care problem.

(e) Retroactive Reviews. The Division may require that the Provider demonstrate that the changes in costs have actually occurred and that the year end cost report substantiates the financial condition stated in the petition. If the Provider fails to provide evidence of such costs within 45 days of the Division request, the Division may retroactively reverse the adjustment.

(2) Effective Date. An administrative adjustment will be effective on the later of the date the petition is filed with the Division or the date on which the event that is the basis of the petition is completed.

(3) Standard of Review. In reviewing the petition, the Division will consider the following:

(a) Whether the adjustment would result in a significant difference in the rate;

(b) The costs of other Providers offering the same or comparable level of care;
(c) The collectability of over-payments by the Department of Transitional Assistance. The Division will notify the Department of Transitional Assistance of the petition.
(d) The Division will review petitions in accordance with the criteria set forth in the regulation in effect in the year in which they are received by the Division, notwithstanding the effective date.

(4) Types of Petitions.
(a) Substantial Capital Expenditures. A Provider may petition for an administrative adjustment for a substantial capital expenditure of at least $10,000 for Improvements and Limited Life Assets and $5,000 for Equipment if it has either made, or expects to make, a substantial capital expenditure that meets the criteria set forth below.
1. Qualifying expenses. The Provider may petition for recognition of increased depreciation and interest expense as a result of the expenditure. The Provider may not petition for Mortgage Acquisition Costs, an equity adjustment or increased operating costs as a result of the expenditure.
2. Expenditures not subject to Determination of Need. For Improvements, the expenditure amount must be at least 1.5 times the allowable annual Base Year depreciation expense of Building, Improvements and Limited Life Assets. For Equipment, the expenditure amount must be at least 1.5 times the allowable Base Year depreciation on Equipment.
3. Expenditures subject to Determination of Need. If the expenditure is subject to Determination of Need approval, the Provider may petition for an adjustment after the Department has determined that need exists for the project and after the time for making an appeal to the Health Facilities Appeals Board has expired or all administrative and judicial reviews of the Department's determination have been concluded. The Provider may petition for an adjustment before the Department has made a determination on the project if the Commissioner of Public Health requests that the Division determine the appropriate amount of an adjustment before a Determination of Need is made with respect to the Provider's proposed expenditure.
4. Limitation on Capital. The maximum amount of fixed costs and equity allowable under 114.2 CMR 4.11(4)(a)2 and 3 is $17.29. For expenditures occurring on or after July 1, 2004, the maximum amount of fixed costs and equity allowable under 114.2 CMR 4.11(4)(a)2 and 3 is $22.56. If the Provider has not yet incurred the expenses, it must submit satisfactory evidence of its commitment to incur the expenditure.
5. Whenever a capital petition is granted, the provider's allowable basis will be adjusted by increasing the accumulated depreciation by the amounts included in the rates from the effective date of the petition.
(b) New Governmental Requirements. A Provider may petition for an administrative adjustment if it has incurred, or presents satisfactory evidence of a commitment to incur, substantially different costs necessary to satisfy new requirements of a governmental unit of the Commonwealth or the federal government. Such requirements must be related to provision of resident care. An increase in existing government requirements is not

considered a new government requirement. The Division will not approve a petition for costs incurred to correct Department of Public Health Resident care deficiencies.

(c) Certain Increases in Operating Costs. A Provider may petition for an adjustment if it has experienced unusual or unforeseen increases in operating costs that are not reflected in the rate. Unusual and unforeseen circumstances are events of catastrophic nature (i.e. fire, flood, or earthquake). The cost increases must gravely threaten the financial stability of the Provider. In measuring the financial stability of the Provider, the Division will consider all of the Provider's expenditures and revenues.

(d) Receiver Fees. A receiver appointed under M.G.L. c. 111, s. 72N may petition for a rate adjustment to reimburse reasonable receiver compensation and payment of his or her bond.

1. The receiver must submit detailed invoices that document the hours expended, a brief description of each activity and the hourly rate. The Division will limit the reimbursement to the reasonable and necessary cost to safeguard the health, safety and continuity of care to Residents and to protect them from adverse health effects of unsuitable transfer.

2. The Division will limit reasonable receiver compensation to the lower of actual receiver fees or $10,000 for the first 30 days, $7,500 for the second 30 days, $2,500 for the third 30 days and $1,500 for each 30-day period thereafter. The Division may include additional receiver compensation if both the Department of Public Health and the Department of Transitional Assistance approve additional compensation to the receiver due to unique circumstances. The Division, the Department, and the Department of Transitional Assistance will evaluate such requests for additional compensation for reasonableness.

(e) Transfer of a Facility If a facility is transferred during the first six months of the year subsequent to the Base Year, the buyer may file a petition requesting that the Division use the buyer's cost report to determine its rate. The buyer must demonstrate that use of the seller's Base Year cost report is not appropriate to project rate year costs. The Division will determine whether use of the buyer's cost report is appropriate to reflect reasonable and necessary patient care costs. The Division will make the appropriate adjustments to reflect the use of a non-Base Year cost report.

4.12: Special Provisions

(1) Notice of Proposed Rate. The Division will send the Provider a notice of the proposed rate as follows:

(a) Desk Audit. Prior to certification of a prospective rate based upon a Desk Audit, the Division will send the Provider a notice of the proposed rate and a copy of adjustments at least ten calendar days prior to the scheduled date of certification. The Provider may comment, in writing, on the proposed rate and adjustments during the period between the notice and scheduled date of Division action. Providers requiring additional time to respond may request that the Division postpone the scheduled certification.

(b) Field Audit. The Division will not send a notice prior to certification of a proposed rate that is based upon a Field Audit if the rate is amended solely to incorporate Field Audit adjustments which have been discussed at an Exit

Conference. The Division will provide a copy of the Field Audit adjustments to the Provider following the Exit Conference.

(2) Rate Filings. The Division will file certified rates of payment for Resident Care Facilities with the Secretary of the Commonwealth.

(3) Appeals. Any Provider aggrieved by a rate of payment established pursuant to 114.2 CMR 4.00 may file an appeal with the Division of Administrative Law Appeals, established under M.G.L. c. 7, s.4H within 30 days of the filing of any such rate with the State Secretary.

(4) Pending Appeal. The pendency of a proceeding or hearing may not be construed to prevent the Division from re-determining a rate of payment for any reason the Division may consider appropriate under M.G.L. c. 118G, and the Division shall have the right to request information pursuant to 114.2 CMR 4.03(7) and 4.04 notwithstanding the pendency of any such proceeding or hearing.

(5) Adjustments to the Prospective Rates. The Division may at any time, adjust the Provider's rates if the Provider has reduced costs by eliminating services or transferring costs or services to other persons, entities or programs.

(6) Information Bulletins. The Division may issue administrative information bulletins to clarify provisions of 114.2 CMR 4.00, which shall be deemed to be incorporated in 114.2 CMR 4.00. The Division will file with the State Secretary, distribute copies to Providers, and make the bulletins accessible to the public at the Division's offices during business hours.

(7) Severability. The provisions of 114.2 CMR 4.00 are severable. If any provision of 114.2 CMR 4.00 or the application of any provision of 114.2 CMR 4.00 is held invalid or unconstitutional, such provision will not be construed to affect the validity or constitutionality of any other provision of 114.2 CMR 4.00 or the application of any other provision.

REGULATORY AUTHORITY
114.2 CMR 4.00: M.G.L. c. 118G.